DEPARTMENT OF THE NAVY
NAVAL HEALTHCARE SUPPORT OFFICE
BOX 140
JACKSONVILLE FL 32212-0140

INPUT THE FOLLOWING DATA  PRESS TAB TO START

RANK RANK NAME NAME

SSN SSN DESIGNATOR DESIG

CORPS CORPS

This information will be used to fill fields on this form.  Print out this form, follow the directions and send the package to us.  Certified mail is the preferred way to return the package.

Dear RANK NAME

Please provide copies of all checked items and complete the forms in their entirety as identified in the cover letter with the enclosure.

**USE ONLY BLACK INK**
**TO CORRECT AN ERROR, DRAW A SINGLE LINE THROUGH THE ERROR, IN BLACK INK, AND INITIAL TO THE RIGHT OF THE LINE.**
**DO NOT USE CORRECTION FLUID/TAPE UNDER ANY CIRCUMSTANCE**

These guidelines should assist you with the completion of the **renewal** package:

**1. PERSONAL AND PROFESSIONAL INFORMATION SHEET (PPIS): DEMOGRAPHICS**
Complete all information requested. Complete day/month/year time frames in the "from-to" fields. If the information is not applicable, write "**N/A**" in the space and draw a line through the remaining lines. Sign and date in the appropriate space. Please address the information regarding professional liability carrier and participation in continuing education.

Should you wish to attach a curriculum vitae/resume, ensure it is current. Please sign and date it with initials on each page in the lower right corner.

**2 HEALTH STATUS/ABILITY TO PERFORM:**
Please respond to the questions that address this area. If you answer "**yes**" (except 2a) to any of the questions, provide a brief, factual response in the spaces below the questions.
**Do not send a copy of a physical examination.**

**3. MALPRACTICE, LICENSURE, AND LEGAL HISTORY:**
Please respond to the questions that address this area. If you answer "**yes**" to any of the questions, provide a brief, factual response in the spaces below the questions.

**4. RESERVE INFORMATION:** Please complete the information regarding Naval Reserve Unit, Naval Air Reserve or Naval & Marine Corps Reserve Center, Naval Reserve Readiness Command – as applicable.

**5. RESERVE TRAINING HISTORY:** Self-explanatory.

**6. OTHER PROFESSIONAL DOCUMENTS:**
You may submit copies of any other associated training (CEU) to your profession. This is **not** required. However, you will attest to CEU participation on the PPIS.

**7. PROFESSIONAL EDUCATION AND TRAINING:** Provide copies of diplomas for education/training completed within the **past two years**. CCPD is required to primary source verify all licenses/certificates held. Should you allow any to lapse/expire, please note this on the PPIS as CCPD is required to primary source verify the document at time of lapse/expiration to evaluate status.

**8. CONTINUING EDUCATION AND TRAINING:** Self-explanatory.

**9. CIVILIAN EMPLOYMENT INQUIRY:**
(Ensure all addresses and phone numbers are complete and accurate).

**PEER REFERENCES:**
(Ensure all addresses and phone numbers are complete and accurate).

**PEER INQUIRIES:** (Ensure all addresses and phone numbers are complete and accurate).

***PEER*** - is a person who has equal educational standing and has worked with you in same specialty.

***PEER*** - *is not* a family member or partner.

CCPD will mail two Professional Peer Inquiry forms (NHSOJAX 6010/3) and the Supervisor/Department Head/Chief of Service Civilian Employment Inquiry form(NHSOJAX 6010/13) to the individuals that have been identified on your PPIS, for completion. In addition, a copy of your signed and dated consent and release form, and a self-addressed envelope addressed to the Naval Healthcare Support Office will be included (so that the individuals can mail them **directly** upon completion).

**10. PROFESSIONAL ASSIGNMENTS:** Self-explanatory.

**CONSENT and RELEASE/PRIVACY ACT and DISCLOSURE STATEMENT**
Please read, sign and date in the appropriate space.

**PHOTO:**
Please provide a recent photograph, preferably a professional photograph of yourself **alone & without** other family members, friends or pets. It may be a Polaroid, but **not** a scanned or xeroxed copy. Ensure that the photograph is labeled with your name, social security number and date.

# ALERT ALERT ALERT

You have received the **INCORRECT** package if you are an ADVANCED NURSE PRACTITIONER with one of the below Sub-Specialty Code (SSC) assignments from the Bureau of Medicine and Surgery.

| Sub-Specialty Code | TITLE |
|---|---|
| 1972 | Nurse Anesthesia |
| 1974 | Pediatric Nurse Practitioner |
| 1976 | Family Nurse Practitioner |
| 1980 | Women's Health Nurse Practitioner |
| 1981 | Nurse Mid-Wife |

Call CCPD Nurse Corps/ICF Division at 800-566-8494 ext. 8131 or 8132 as soon as possible.

**DO NOT DISCARD THIS PACKAGE UNTIL DIRECTED BY THIS DIVISION.**

# ALERT ALERT ALERT

NAVAL HEALTHCARE SUPPORT OFFICE
CENTRALIZED CREDENTIALS REVIEW AND PRIVILEGING DEPARTMENT
BOX 140 CODE 07
JACKSONVILLE, FLORIDA 32212-0140

**PERSONAL AND PROFESSIONAL INFORMATION SHEET**
**NON- PRIVILEGED PROVIDER**

## PRIVACY ACT STATEMENT

**AUTHORITY**: 10 U.S.C. Chapter 55 and Section 8067 and 8013 and EO 9397.
**PURPOSE**: To evaluate providers' formal education, training, clinical experience, and evidence of physical, moral, and ethical capacities as they relate to the credentials function and recommendations as to practitioners' competence to treat certain conditions and perform certain medical procedures and to determine clinical support staff provider competence.
**ROUTINE USE**: Information may be released to government boards or agencies or professional societies or organizations if needed to license or monitor health care providers' professional standards. Information may also be released to civilian medical institutions or organizations where the practitioner is applying for staff privileges during or after separation from the service or applying for employment with regards to clinical support staff providers.
**DISCLOSURE IS VOLUNTARY**: However, failure to provide information may result in limitation or termination of clinical privileges.

Complete all items and sections. List all dates as day-month-year. Use "NA" if not applicable. "YES" answers require full explanation in the comments section or on an attached sheet of paper (indicate by number and section on the attached paper those items being commented upon).

**1.** RANK NAME SSN CORPS DESIG

Maiden/Alias (Last, First, MI): _____

Date of Birth: _____ Branch of Service: USNR

NOBC/SSP codes: _____

Home Address: _____

Home Phone: (___) _____ Fax: (___) _____ E-Mail: _____

Work address: _____

**2. HEALTH STATUS AND ABILITY TO PERFORM (Answer Yes or No)**
(Note: Explain all Yes answers in comments Section)

___a. Have you met the Navy's requirement to have a completed annual physical examination, either long or short form, within the past 12 months? (**If not, please explain**)
___b. Do you currently have any physical or mental impairments that could limit your clinical abilities?
___c. Are you currently under or have you ever received treatment for an alcohol or drug-related condition?
___d. Have you ever been arrested or detained for an alcohol or drug-related incident?
___e. Have you ever been involved in the unlawful use of controlled substances?

Comments: _____

**RE:** RANK NAME SSN CORPS DESIG

**3. MALPRACTICE, LICENSURE, AND LEGAL HISTORY (Yes or No)**

(Note: Explain ALL YES answers in Comments Sections)

___a. Have you ever been the subject of a malpractice claim? (Indicate final disposition or current status of claim in comments.)

___b. Have you ever been charged or a defendant in a felony or misdemeanor case? (Indicate final disposition of case in comments.)

___c. Have you ever been the subject of investigation resulting in the termination of employment or a contractual arrangement?

___d. Have you ever voluntarily resigned or otherwise disassociated yourself from employment or practice after being notified of intent to start action against you?

___e. Have you ever voluntarily or involuntarily withdrawn, reduced or terminated your staff appointment (membership)?

___f. Have you ever voluntarily or involuntarily withdrawn, reduced or terminated, or lost your clinical privileges?

___g. Has there been previously successful or currently pending challenges, revocation, or restriction to any license, certification, or registration (State, district, or Drug Enforcement Agency) to practice in any jurisdiction, or the voluntary/involuntary relinquishment of such licensure, certification, or registration?

___h. Are you now or have you ever been required to appear before any medical or state regulatory authority regardless of the result, concerning your status as an impaired, hindered, or otherwise restricted provider?

Comments: _____

_____

_____

**4. RESERVE INFORMATION**

a. RESERVE UNIT and RUIC: _____

b. READINESS or RESERVE CENTER and UIC: _____

c. NAVAL AIR RESERVE OR RESERVE CENTER: _____

d. READINESS COMMAND (REDCOM): _____

e. BILLET ASSIGNED: _____

**5. RESERVE TRAINING HISTORY**

a. OIS/DCO (Officer Indoctrination School/Direct Commissioned Officer School) Completion Date: _____

b. List ANNUAL TRAINING (AT), ACTIVE DUTY FOR TRAINING (ADT), and ACTIVE DUTY FOR SPECIAL WORK (ADSW).

| Facility/Location | Clinical | From | To |
|---|---|---|---|
| (Example) NH Groton | YES/NO | 12SEP94 | 29SEP94 |
| | | | |
| | | | |

**RE:** RANK NAME CORPS SSN DESIG

c. Do you perform drills at a military treatment facility? _____
If yes, provide information listed below for the:

| Facility/Location | Capacity | Frequency |
|---|---|---|
| (Example) NH Jacksonville | Med/Surg Nursing | 48 drills/year |
| | | |
| | | |

**6 OTHER INFORMATION** (Include any additional information that you wish to bring to the attention of the credentials office.)
Comments: _____

**7. PROFESSIONAL EDUCATION AND TRAINING: (if you have attended any training, list most recent training in the past two years.)**

| Additional Training, additional degrees Institution (Name and Location) | Specialty | Type (MSN,PH.D.) | From | To |
|---|---|---|---|---|
| | | | | |
| | | | | |

**I hereby attest that I understand the requirement that I be certified in a CPR course provided by the American Heart Association/HEALTHCARE PROVIDER or the American Red Cross/PROFESSIONAL RESCUER while I am in the Naval Reserves per BUMEDINST 1500.15A. I understand that I am responsible for providing documentation of my certificate upon request (i.e. AT, ADT, IDTT).**

_____ _____
**Signature** **Date**

**8. CONTINUING EDUCATION HOURS**
Have you fulfilled the state licensure requirements for continuing education during the past 2 years?
_____**YES** _____**NO** (If not, please explain)
Have you participated in continuing education in your area of specialization during the past 2 years?
_____**YES** _____**NO** (If not, please explain.)

Comments: _____

**9. SUPERVISOR/DEPARTMENT HEAD/CHIEF OF SERVICE REFERENCES:**

Name _____ Work Phone (___) _____ FAX (___) _____
Full Address _____

**RE:** RANK NAME CORPS SSN DESIG

**PEER REFERENCES** Please provide two peer references who can attest to your qualifications **based on current clinical experience within the past two years.**

Name _____ Work Phone (___) _____ FAX (___) _____
Address _____

Name _____ Work Phone (___) _____ FAX (___) _____
Address _____

**10. PROFESSIONAL ASSIGNMENTS** Please provide all information requested for each place you have been employed for the past two years. Indicate if direct patient care was involved. If yes, **was it in your current specialty**?

List in chronological order with the most recent first, and identify gaps in employment history.

Facility/Institution _____ PHONE (___) _____ FAX (___) _____
Address _____
Direct Patient Care (Y/N) _____ if yes how many hours per week _____
Position/Specialty _____
Point of Contact _____ From _____ To _____

Facility/Institution _____ PHONE (___) _____ FAX (___) _____
Address _____
Direct Patient Care (Y/N) _____ if yes how many hours per week _____
Position/Specialty _____
Point of Contact _____ From _____ To _____

** If currently working in a non-clinical setting, or working less than 10 clinical hours a week, briefly describe your current occupation and job activities**:

I affirm and attest to the complete and correct information I have provided. I have the responsibility to comply with all credentialing policies and procedures, and Code of Ethics/Standards of Conduct. I will keep my file current by informing the Naval Healthcare Support Office of any changes; including but not limited to: my demographic information, my state license(s)/certification(s), any change in my employment status at any facility, or any professional adverse action taken against me.

Signature:_____ Date:_____

INDIVIDUAL CREDENTIALS/PROFESSIONAL FILE

# CONSENT AND RELEASE/PRIVACY ACT STATEMENT

**RE:** RANK NAME CORPS SSN DESIG

As a clinical support staff member or by applying for medical/dental staff membership of the Naval Healthcare Support Office, Jacksonville, Florida, I hereby make the following authorizations:

REFERENCES: Authorize the Naval Healthcare Support Office, Jacksonville, Florida, and its representatives to consult with my current and prior associates and others who may have information regarding my clinical competence and other qualifications and to verify information in my file;

INSPECTION OF RECORDS: Consent to the inspection by the Naval Healthcare Support Office, Jacksonville, Florida, and its representatives, of all records and documents, that would evaluate my competence and professional, moral, and ethical qualifications;

LIABILITY INSURANCE: Authorize release of information from current and prior liability insurance carrier(s) regarding any and all information related to coverage and claim history under their company(ies);

RELEASE FROM LIABILITY: Release from liability any and all individuals and organizations who provide information to the Naval Healthcare Support Office, Jacksonville, Florida, and its representatives, in good faith and without malice concerning my clinical competence, ethics, moral character and any other qualifications. (Peer review activities are protected under the Health Care Quality Improvement Act of 1986 (HCQIA).).

TIME FRAME FOR AUTHORIZATION: Acknowledge that this form and any copies thereof may be used as authorization for securing information for two years from the date signed.

1. **AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):** 10 U.S.C. Chapter 55 and Section 8067 and 8013 and EO 9397.

2. **PURPOSE**: To evaluate each practitioner's/provider's formal education, training, clinical experience, and evidence of physical, moral, and ethical capacities and to assist the credentials and privileging function in making recommendations with regard to the practitioner's competence to treat certain conditions and perform certain medical procedures and to determine competence for clinical support staff providers.

3. **ROUTINE USE**: Information may be released to government boards or agencies, or professional societies or organizations if needed to license or monitor professional standards of health care practitioners/providers. It may also be released to civilian medical institutions or organizations where the practitioner is applying for staff privileges during or after separation from the service or applying for employment with regards to clinical support staff providers.

4. **DISCLOSURE IS MANDATORY**: In the case of all personnel, the requested information is mandatory because of the need to document all credentialing and quality assurance (performance improvement) data. If the requested information is not furnished, further action on your ICF/IPF will not be possible. This all inclusive privacy act statement will apply to all requests for personal information made by personnel for credentials review purposes and will become a permanent part of your ICF/IPF.

Your signature acknowledges that you have been advised of the foregoing. If requested, a copy of this form will be furnished to you.

| | SSN | |
|---|---|---|
| SIGNATURE OF MEMBER | SSN OF MEMBER | DATE |